Assessing Late Career Practitioners:
Policies and Procedures for Age-based Screening

A Guideline from

California Public Protection and Physician Health

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This version shows changes based on the changes requested by CMA in their letter to CPPPPH dated 5-27-15. The changes are on pages 6 and 7; they are shown in track changes.

Copies sent to the Workgroup and the CPPPH Board for review at the Board meeting on 6-18-15.

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I. INTRODUCTION

The implications of greater human longevity generally and a rapidly increasing work-life expectancy are complex and the subject of intense study, particularly as they relate to the delivery of health care. Ensuring that the U. S. health care system will have the workforce capacity needed to deliver care to the increasing numbers of patients that have been projected has been identified as a priority.

On the one hand, studies show that greater levels of experience in medicine, as in other industries, result in higher quality care. We ascribe benefit to the greater experience accumulated with more years of practice being brought to bear on patient-care decisions by physicians and other health care workers.

On the other hand, studies also demonstrate that the effects of aging directly impact the specific physiological and cognitive functions relied upon by physicians in carrying out their job-related responsibilities. In fact, studies have found a direct correlation between decline in these areas of function and adverse outcomes for patients. The studies cited in the appendix necessitate an examination of how to evaluate and address any decline in levels of function that might impact patient care and a consideration of whether using age as a factor in our evaluation mechanisms is an effective way of protecting patients.

The legal framework surrounding this issue is responsible for additional complicating forces. Both Federal and State law mandate that entities that employ, contract with or grant privileges to physicians to provide services to patients—including hospitals, medical staffs, and physician groups —engage in active oversight of the quality of care rendered by physicians practicing at their facilities. Case law clearly establishes that hospitals and physician groups can be held directly liable for injuries caused to patients by physicians where there was evidence of deficiencies in the physician's skills or judgment that posed a danger to patients.

The law does not, however, allow unfettered discretion to entities charged with the responsibility of quality oversight. The law has created an expansive view of the property right of members of medical staffs to practice their trade free from arbitrary actions by hospitals, medical staffs and others. This includes a physician's right to be free from discrimination based on race, color, gender, sexual orientation, national origin, age and disability. Thus is created the dynamic tension between the need to protect the public and the patient and the need to protect the individual healthcare provider.

A. STATEMENT OF PURPOSE

This document is intended to assist all those in medical staffs, medical groups, and other entities that have responsibility for decisions related to evaluating a practitioner's health and wellbeing as they impact the practitioner's ability to practice medicine safely. (Hereinafter, the document uses "medical staff" to refer to all the entities with this responsibility.) The document describes guidelines and principles and provides information specific and detailed enough to form the basis for decisions to be made by each entity. It does not replace the judgment of the decision makers applied to individual circumstances.

This paper will also review the evolution and impact of age and disability discrimination laws on the options available for evaluating physician competency. As will be seen, age and disability discrimination laws have unique aspects that in many ways grant flexibility to institutions in shaping policies and actions designed to address quality and protect patients. These laws are complex and care must be exercised in creating and implementing policies so as to maintain the values that underlie the extensive network of laws that prohibit discrimination. This paper will examine the intersections of the multiple competing forces in the discussion of the available options for assessing physicians who choose to work late into their careers.

Most importantly, this paper will posit that this issue can be properly addressed only if it is addressed by all stakeholders as a shared responsibility: by practitioners who, ideally, should assess their own level of skill and any changes which might impact their ability to deliver quality care and by institutions responsible for maintaining quality care and protection of the patients. To be effective and successful, policies and procedures must balance the interests of all involved in assuring safety of patient care.

A necessary starting point is an examination of the studies that identify and quantify the impact of age on quality, and the implications of these data for entities charged with ensuring quality.

B. THE EVIDENCE ON WHICH THIS DOCUMENT IS BASED

The guidelines in this document are designated by the author as Level C, "the consensus of expert opinion," under the American Academy of Family Physicians' rating system for levels of evidence used, as described in its journal, *American Family Physician*.

C. THE AUTHORS

This document was prepared by a workgroup comprised on persons who are members of ~~Procopio, Cory, Hargreaves & Savitch LLP at the request of California Public Protection and Physician Health and with input from representatives of~~ the California Medical Association, the California Hospital Association's Center for Healthcare Medical Executives, and California Public Protection and Physician Health, and attorneys from Procopio, Cory, Hargreaves & Savitch LLP -(the "Workgroup").

Review and comments were requested from other interested stakeholders, including nationally recognized experts in the evaluation of health care professionals. All comments received were considered, and corresponding changes approved by the Workgroup were incorporated into this document.

~~It~ The document was adopted by the CPPPH Board on April 14, 2015. ~~The document~~ It will be subject to periodic review and revision to incorporate new developments. If the document is revised, it will be circulated for comment again and published with a new date.

D. DISCLAIMER

The guidelines set forth in this document are general in nature, do not constitute legal advice and should not be used as the sole basis for decision- or policy-making or as a substitute for obtaining competent legal counsel.

The guidelines contained herein are not entirely inclusive, exclusive or exhaustive of all reasonable methods or approaches to age-based screening. This document does not advocate in favor of or against mandatory or permissive age-based screening nor is it intended to replace the judgment of decision-makers applied to individual circumstances. While these guidelines take into account variations in practice settings, resources, and common physician skills and characteristics, they cannot address the unique circumstances of each situation.

Neither the Workgroup nor its participants makes any warranty, express or implied, including the warranties of merchantability and fitness for a particular purpose, or assume any legal liability or responsibility for the content, including its accuracy, completeness, efficacy or value, or for any method, process or policy described or referenced herein. The guidelines reflected in this document shall not be attributed to any one of the Workgroup participants.

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~~In accordance with a rating system for levels of evidence used by the American Academy of Family Physicians, described in its journal, *American Family Physician,* the statements or recommendations in this guideline are designated as Level C when ranking the evidence on which they are based. Level C is the consensus of expert opinion.~~

~~This document was prepared by persons from the California Medical Association, the California Hospital Association's Center for Healthcare Medical Executives, and California Public Protection and Physician Health, working with attorneys from Procopio, Cory, Hargreaves & Savitch LLP. They participated as individuals, contributing their experience and expertise to the deliberations, but they did not represent their organizations and the final document is not the official policy of those organizations. It is a document from California Public Protection and Physician Health (CPPPH).~~

~~Review and comments were requested from all interested parties, including nationally recognized experts in the evaluation of health care professionals. The final draft was prepared after every comment was considered and changes were made to the document to incorporate the comments adopted by the Work Group~~.

II. THE CLINICAL CASE FOR ASSESSING LATE-CAREER PRACTITIONERS

According to the American Medical Association (AMA), in 2012, 42% of the nation's one million physicians were older than 55 and 21% were older than 65.[1] This is compared with 35% and 18% respectively in 2006.[2] The rising number of physicians practicing later in life raises concerns about the potential impact aging physicians have on patient safety. This is

[1] Boodman, Sandra, "Aging Doctors Face Greater Scrutiny," *Kaiser Health News*, December 10, 2012. http://www.kaiserhealthnews.org/stories/2012/december/11/aging-doctors-face-greater-scrutiny.aspx
[2] *Id.*

particularly troubling given the various studies finding that when people reach their 60s and 70s, there is often a significant and progressive decline in cognitive and physical skills. This is true of physicians as well. For example, a 1994 Harvard study found that "overall, physicians scored higher in cognitive functioning from ages 25-55, but thereafter there was a consistent and more precipitous decline with increasing age in the areas of cognitive function (as measured by the MicroCog™ assessment tool), inductive reasoning, verbal memory, and overall reasoning."[3]

A 2006 report found that patient mortality rates in some complex operations were higher when the surgeons were older than 60 than for their younger colleagues.[4]

A retrospective review of 148 doctors with performance problems demonstrated relative deficits on tests in sequencing, attention, logical analysis, eye-hand coordination, and both verbal and non-verbal learning.[5] The study concluded these deficits were sufficient to explain the performance difficulties.[6]

Published studies provide evidence that as physicians age, they experience a higher likelihood of physical and cognitive limitations or impairment than their younger colleagues, which can have a potentially negative impact on patient care and safety. This is not to say that all physicians over a certain age pose a safety risk, as many continue to function without difficulty (without significant decrease of either cognitive or physical skill and performance) into their 70s and 80s. Determining which individuals may pose a safety risk is the duty of those in the hospital or other medical setting who are responsible for protection of patients and quality of care delivered. Because many of the diseases and processes that are more likely to occur with increasing age happen insidiously and with few or no symptoms recognized by the physician nor signs apparent to those around him/her, screening assessments are one way to provide the first information on which those determinations can be made. Screening is used to indicate whether a physician's abilities match his or her practice requirements or whether further testing and evaluation are needed before that judgment can be reached.

III. CRAFTING A POLICY: ELEMENTS OF AN EFFECTIVE POLICY

The policy that authorizes age-based screening should articulate and document the purpose, the rationale, and the authority for requiring the assessment. Those who may be called upon to defend an institution's practices against a legal challenge will look first to the policy. The policy should address key issues clearly and directly in a way that guides and governs the steps used to implement it. The policy should:

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[3] Burroughs MD, MBA, FACHE, FACPE, Jonathan H., Hogan, Esq., James B., and Richter, Esq., Jennifer H., "The Aging Physician: Balancing Safety, Respect, and Compliance," *Med Staff News*, March 2013 http://www.hallrender.com/health_care_law/library/articles/1465/MedStaff_News_AHLA_March_2013.pdf (citing Powell M.D., Douglass H., "Profiles in Cognitive Aging," *Harvard University Press*, December 1994).

[4] Waljee, M.D., M.P.H., Jennifer F, Greenfield, M.D., Lazar J., Dimick, M.D., M.P.H., Justin B., and Birkmeyer, M.D., John D., "Surgeon Age and Operative Mortality in the United States," *Annals of Surgery*, Vol. 244, No. 3, September 2006.

[5] Pitkanen. "Doctor's Health and Fitness to Practice: Performance Problems in Doctors and Cognitive Impairments." *Occup. Med.*, 2008.

[6] *Id*.

1) specify that the requirement for assessment applies equally to all members of the medical staff who have reached the specified age
2) state that the requirement for evaluation is based solely on the age of the practitioner.

   Note that this policy is unrelated to an assessment made "for cause" or in response to an indication of compromised performance. Assessments for cause are addressed in other documents: California Medical Association OnCall Document #5177 *Guidelines for Hospital Medical Staff Wellbeing Committees Policies and Procedures* [September 2013] and *Evaluations of Healthcare Professionals* [CPPPH 2013]
3) specify the age at which the first screening is required

   The decision about the age at which a policy takes effect has important implications for a potential legal challenge to the policy. In order to defend a policy on patient-safety grounds, the age at which the policy goes into effect should have a direct connection to the age at which there is an increased risk of age-related impairments as documented in the literature. Institutions should closely monitor the research related to age-related impairments and regularly reassess their policies to ensure that the age designated in the policy is accurately aligned with the current literature on the subject.
4) specify that the requirement is made a part of the reappointment and privileging process
5) establish the frequency with which reassessments are required for reappointment
6) establish who pays each of the costs of the assessment

   There is no one recommended way to handle costs. Appropriate choices include payment being the responsibility of the person being assessed, the responsibility of the medical staff or medical group, or a shared responsibility. See *Guidelines for Evaluation of Healthcare Professionals* [CPPPH 2013]
7) establish the requirement that the practitioner provide a release allowing evaluators' reports to be given to the medical staff Wellbeing Committee, regardless of who paid for the assessment(s)
8) establish what information is protected and kept confidential within the Wellbeing Committee and under what authority it is protected

   The policy should specify that all information related to the screening process is kept confidential, what records are generated, how the information will be protected.
9) specify the roles, responsibilities and charges to each committee or officer of the medical staff or medical group in implementing the policy

   Because of its charge to advise and assist the members of the medical staff and to maintain confidentiality of the information except when the safety of a patient is threatened, the Wellbeing Committee is the most appropriate committee to be responsible for implementation of the policy up to the delivery of its recommendation to the practitioner and to the Credentials Committee. The policy should establish that the function of the Wellbeing Committee in coordinating this process includes the duty

to support the practitioner. This charge should be added to the bylaws section that specifies the duties of the Wellbeing Committee.

10) establish that the Wellbeing Committee has no authority to take disciplinary action or any action related to privileging, but will report its findings to the Credentials Committee

11) establish that the Wellbeing Committee has the authority to set criteria for identifying qualified evaluators, to require qualified evaluators, and to approve the choice of the evaluator(s) for each practitioner. For qualifications of those who conduct evaluations, see *Guidelines for Evaluation of Healthcare Professionals* [CPPPH 2013].

12) authorize the Wellbeing Committee to recommend additional evaluation after reviewing the reports of screening assessments

13) establish that the charge to the Wellbeing Committee is to evaluate the information received and to advise the practitioner and the Credentials Committee

14) specify the consequences to the practitioner of failure to comply with all the requests during the assessment process or failure to complete the assessment process, i.e., such failure will result in an incomplete application and lapse of privileges

IV. ADOPTING THE POLICY

Crafting a policy is only the first step. Involving and informing all members of the medical community and allowing sufficient time for review, questions and discussion, are considered necessary for a smooth and successful adoption of the policy. It is helpful to circulate information about the policy in advance and provide the supporting research on which it is based, showing the correlation between age and adverse patient outcomes.

It is critical that all members of the medical staff or medical group understand that the policy is aimed at both protecting patient safety and safeguarding the career of the practitioner and that it incorporates protections against discrimination of any sort.

Special outreach to those impacted by the policy, and those soon to be impacted, may be in order. For example, the medical staff leadership might personally contact every practitioner affected by the policy during the period that the draft is being developed to engage them in a review of the principles involved and to address any questions or concerns they may have.

After the policy is adopted and implemented, it is helpful to reiterate, on a regular schedule, the principles on which the policy is based and how they address the interests of all involved. An annual educational activity designed for the entire medical staff is helpful in maintaining support for the policy.

V. IMPLEMENTING THE POLICY

The Wellbeing Committee should begin by defining the procedures it will follow and making them known to the members of the medical staff. The procedures should guide the actions of the Wellbeing Committee so that each case is handled similarly and in accordance with the procedures. The procedures should address each of the following elements.

A. ADMINISTERING THE SCREENING ASSESSMENT

A screening assessment is a combination of elements and reports considered together. The Wellbeing Committee should identify the elements to be included and the experts who will identify the screening instruments to be used. The four core elements – physical examination, assessments from peers and co-workers, and assessment of cognitive function – are discussed below.

In order to defend a policy against a legal challenge, it is important that the screening (and any further assessments) required accurately assesses a physician's capacity to perform the privileges currently held or requested at the time of reappointment.

1. HISTORY AND PHYSICAL EXAMINATION

There should be a general history and physical examination including a screening for depression/other mental health or emotional issues, a screening for alcohol/substance abuse/addiction, and tests of both hearing and vision.

2. PEER ASSESSMENTS

There should be a review of the practitioner's current performance conducted by a peer. Those who conduct such peer assessments may be nominated by the practitioner but must be approved by the Wellbeing Committee. (The Wellbeing Committee should have presented a list of pre-approved assessors. It is recognized that peer assessments may be influenced by personal relationships that must be taken into account when the Wellbeing Committee approves the person to make the peer assessment.

The person making and reporting the peer assessment should include observations of each of the ACGME Core Competency areas: Professionalism, Interpersonal and Communication Skill, Medical Knowledge, Practice-based Learning and Improvement Patient Care, and Systems-based Practice. An example of a peer assessment form is in Appendix B.

3. OBSERVATIONS FROM OTHERS IN THE CLINICAL SETTING

Because a change in behavior may be an early sign of decline in professional performance and because such a change may be noticed first by personnel in the clinical setting, it is important to include observations and information from persons in the work setting. Examples are observation from operating room supervisors for all surgeons, floor managers for non-surgical specialists, and risk management staff for all practitioners. Examples of such reports are in Appendix B.

4. ASSESSMENT OF COGNITIVE FUNCTION

An assessment of cognitive function is an essential element in determining the physician's ability to perform his/her current or requested privileges safely. Screening instruments such as, for example, the MicroCog™, St. Louis University Mental Status (SLUMS) Examination, or Montreal

Cognitive Assessment have been studied and their effectiveness reported. In Appendix A there are notes regarding the validity, predictability and reliability of the instruments that assess cognitive function.

If a recognized screening instrument that tests cognitive function is not to be used, alternative methods should be employed to gather information on which judgments can be made about the practitioner's cognitive abilities. For example, the medical staff could design a combination such as physical examinations repeated at a specific intervals, plus regular peer evaluations from two physicians familiar with the practitioner's work, on a frequency to be determined, and observations by others in the clinical setting.

B. IDENTIFYING QUALIFIED EVALUATORS

The Wellbeing Committee should identify those qualified to conduct and report the screening assessment of cognitive function. See *Evaluations of Healthcare Professionals* (CPPPH 2013)

The Wellbeing Committee should provide a list of two or more qualified evaluators for each element of the assessment process from which the evaluee may choose.

Qualifications of those who conduct and report the results of screening assessments are different from the qualifications required of those who conduct additional testing. Qualifications appropriate for those chosen to conduct the screening include these elements:

- Experience: at least three years' experience in practice in his/her respective specialty
- Previous experience assessing physicians is desirable
- For neuropsychological screening assessment, evidence of specialty training in cognitive and neurological disorders and testing
- For screening for substance use disorders, demonstrated knowledge and understanding of addiction, treatment and recovery
- No conflict of interest or duality of interest with evaluee or referring entity
- Licensure: licensed health care professional with current unrestricted license with no disciplinary history within the previous five years
- Demonstrated ability to provide reports on time, with sufficient and appropriate information to support peer review action

Qualifications appropriate for those chosen to conduct additional testing and evaluation are discussed in *Guidelines for Evaluations Of Health Care Professionals* [CPPPH 2013] and include these additional elements:

- Specialty or subspecialty certification or equivalency
- Previous experience assessing physicians is desirable
- Demonstrated ability to provide reports that describe the nature of any decrements in performance and describe how such decrements or vulnerabilities might affect the ability to perform the tasks required for the evaluee's practice and privileges

C. SCHEDULING THE ENTIRE ASSESSMENT PROCESS

The Wellbeing Committee should coordinate the schedule for the assessment process with the evaluee and all those providing reports. The scheduling of evaluations must allow for sufficient time for each step to be completed. The Committee should remind the evaluee of the policy that specifies that failure of the practitioner to make or keep the scheduled appointments for assessments is considered failure to comply with the process.

D. PROVIDING INFORMATION TO THE EVALUATOR(S) IN ADVANCE

For the screening assessment, the evaluator must know the practitioner's specialty and what privileges are being requested. For additional testing, additional information must be provided to the evaluator. See *Evaluations of Healthcare Professionals* (CPPPH 2013)

E. WHAT IS REQUIRED IN REPORTS FROM THE EVALUATORS TO THE WELLBEING COMMITTEE?

The reports to the Wellbeing Committee should include the evaluator's conclusion stating whether there are or are not findings that may potentially affect the practitioner's professional performance and whether additional testing is needed.

If additional testing is conducted, the reports of the additional evaluation that may include testing should describe the nature of any decrements in performance found and describe how such decrements or vulnerabilities might affect the ability to perform the tasks required for the physician's practice and requested privileges.

Appendix C provides a sample report with a discussion of how it is interpreted in relation to privileging.

F. THE WELLBEING COMMITTEE'S RESPONSE

After reviewing the reports of the screening assessments, the Wellbeing Committee should decide whether to require additional testing in order to make its decision and report to the Credentials Committee.

If the reports from the screening process identify questions that raise concerns about a physician's ability to perform the requested privileges safely, the Wellbeing Committee should review the results with the physician, identify what further evaluation(s) are needed, and provide a list of at least two qualified evaluators. If additional testing and further evaluation are needed, the Wellbeing Committee should coordinate them and help the practitioner schedule them.

Reports of the additional evaluation(s) may indicate vulnerabilities significant enough to warrant ongoing watchfulness for further diminution of skills and abilities, but not sufficient to warrant reduction of privileges at that time. If so, the Wellbeing Committee should design a monitoring process appropriate to the situation and offer to monitor the practitioner on an ongoing schedule appropriate to the situation. In the interactive process with the practitioner, the Wellbeing

Committee can offer such an option with the understanding that the practitioner must sign an agreement with the Wellbeing Committee for the continuing interaction with the Wellbeing Committee for the purpose of being so monitored. The implementation of all steps to carry out such a monitoring agreement should be handled according to the medical staff's policies and procedures for the Wellbeing Committee.

If the practitioner signs such an agreement, the report to the Credentials Committee would be that the practitioner had completed the assessment process. As long as the practitioner cooperates with all elements of the monitoring plan and schedule, and as long as his/her skills and abilities remain sufficient to support safe patient care, no report would be made to the Credentials Committee or MEC.

If the reports indicate an impairment or diminution of skills and abilities sufficient to warrant a modification of privileges, an interactive process between the practitioner and the Wellbeing Committee should be conducted with the goal of helping the practitioner modify his/her privileging request in order to practice competently. For example, institutions can create co-management privileges to transition the practitioner from independent privileges to refer-and-follow privileges. (Refer-and-follow privileges may be defined differently by different institutions, but they can be ambulatory privileges that allow physicians to refer patients to the hospital, order ancillary studies from an outpatient setting, and follow their patients in the hospital.) The Wellbeing Committee can encourage the physician to transition to a part-time hospital practice or reduce the call schedule or to make the decision to retire.

While the Wellbeing Committee's role and function during this process would follow the institution's bylaws, policies and procedures, the Committee's actions should be supportive and respectful and should include recommending approaches for the practitioner to respond to any concerns.

Since the Wellbeing Committee is not a credentialing or disciplinary body, these discussions would not constitute an investigation. Following the discussions, if the practitioner initiates a request for a change to his/her privileges, no reporting to the Medical Board would be required. (See question #3 in Appendix F.) All information resulting from the assessments should remain confidential as products of the Wellbeing Committee, following the policy that establishes what information is protected and kept confidential and under what authority it is protected.

In the event that the report(s) raises concerns that the health of the medical staff member poses an unreasonable risk of harm to patients, and if the medical staff member does not initiate a change in his/her practice and privileges as recommended by the Wellbeing Committee or comply with a monitoring agreement designed by the Wellbeing Committee, that information should be forwarded to the Credentials Committee or the Medical Executive Committee in accordance with the organization's bylaws and/or policies. The Credentials Committee and the Medical Executive Committee (MEC) are responsible for deliberation, determining what action to take, and taking action.

G. REPORTS FROM THE WELLBEING COMMITTEE TO THE CREDENTIALS COMMITTEE

When the Wellbeing Committee determines that it has reached the end of the interactive process with the practitioner and when the Wellbeing Committee has agreed upon its recommendations, the report should be forwarded to the Credentials Committee or the Medical Executive Committee in accordance with the organization's bylaws and/or policies. The report should be one of the following:

- the statement that the practitioner has completed the Committee's assessment process.
- the statement that the practitioner failed to complete the Committee's assessment process and/or failed to complete the subsequent steps in the Committee's process.

The information on which the Wellbeing Committee's report to the Credentials Committee is based should remain confidential with the Wellbeing Committee.

H. MEDICAL STAFF'S RESPONSE TO REPORTED CONCERNS OF AGE-RELATED IMPAIRMENTS

Consistent with the Americans with Disabilities Act (ADA) and/or the Rehabilitation Act, the medical staff must engage in an interactive process with the practitioner and, if possible, make reasonable accommodations to enable him or her to continue to practice safely in light of the concerns named in the reports of the further evaluations performed. Properly doing so could avoid claims for violation of the ADA.

If the concerns are such that they cannot be alleviated by a reasonable accommodation, and if the concerns represent foreseeable and significant threats to patient safety, it would not violate the ADA to require a significant reduction in clinical privileges.

In some situations, but not all, changes or limitations on privileges made by the MEC require a report to the Medical Board of California and the National Practitioners Data Bank. See Appendix F.3: What must be reported?

VI. INFRASTRUCTURE REQUIRED TO IMPLEMENT THE POLICY

For an effective implementation of the different steps of this policy, the medical staff should have in place several elements:

- medical staff services department with sufficient staff support for the Credentialing Committee and the Wellbeing Committee and sufficient time to take on the necessary elements of reappointment process
- wellbeing committee with enough active members who have the appropriate experience and expertise
- capacity to maintain confidential records
- sufficient funding to pay for assessments (if the policy says that the medical staff pays)

- access to a sufficient number of qualified evaluators who can meet the medical staff's need for reports with sufficient information within a certain time frame

Medical staffs without the resources listed above may contract with other entities to perform some or all of the steps involved.

VII. LEGAL CONSIDERATIONS ON WHICH POLICIES ARE BASED

Generally speaking, an employer or medical staff can, and must, take a physician's health into account in both the hiring and privileging processes. See *Joint Commission Comprehensive Accreditation Manual for Hospitals, MS.06.01.05(6).* The American Medical Association's *Code of Medical Ethics* requires physicians to both maintain their health and wellness and, when an issue arises, "take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing." *AMA Code of Medical Ethics Opinion 9.0305- Physician Health and Wellness. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion90305.page#*

Physicians are ethically obligated to report impaired colleagues when they believe the impairment interferes with the colleague's ability to engage safely in professional activities. *Opinion 9.031- Reporting Impaired, Incompetent or Unethical Colleagues. http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page*

Age-based medical screening exams implicate federal and state laws which prohibit discrimination based on age and disabilities. These laws are complex and contain many exceptions and variables which must be factored into any discussion of age-based screening and actions based on the findings of any screening process. The history and development of these laws are set forth in detail in Appendix F.

A. AGE DISCRIMINATION

The federal Age Discrimination in Employment Act (ADEA) and state age discrimination statutes prohibit the arbitrary use of age in decisions that impact the employment status of individuals. These laws apply to practitioners and there are many cases in which physicians have alleged age and other forms of discrimination in challenges to hospital medical staff decisions to impose corrective action. None of the reported cases involve a physician challenge to an age-based screening policy.

While the federal and state laws prohibiting age discrimination declare that age shall not be used to adversely affect any individual, the laws are most noteworthy for their exceptions. Unlike race, religion, nationality and other immutable characteristics, physical and cognitive decline associated with age have been recognized by Congress, state legislatures and courts as posing risks in the workplace, both to the employee and others. This is particularly true when public safety is at issue. Thus, mandatory retirement policies and screening based on age have been imposed through legislation, (e.g., for airline pilots and law enforcement), and by industries responsible for public safety, (e.g., for bus drivers). As set forth in the analysis in Appendix G, the healthcare industry, strangely, has been omitted from legislation allowing for age-based

measures to monitor and ensure patient safety. This has created a great deal of uncertainty for hospitals, medical staffs and physicians considering screening policies.

B. DISABILITY DISCRIMINATION

The federal Rehabilitation Act of 1973 and Americans with Disabilities Act (ADA), as well as state disability discrimination laws, prohibit adverse employment actions based on an individual's disability. Like age discrimination, however, the laws implicitly recognize the right of employers, including hospitals and their medical staffs, to consider a disability in determining whether an individual can safely perform his or her job duties.

Disability discrimination laws do not expressly preclude disability-related inquiries or medical screening examinations. Rather they place certain limits on the stage at which health-related inquiries can be made and on the scope of any inquiry. According to the EEOC, "[t]he ADA's provisions concerning disability-related inquiries and medical examinations reflect Congress's intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can effectively perform the essential functions of the job." See EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000).

An employer may make disability-related inquiries and require a medical examination only if they are "job related and consistent with business necessity." A disability-related inquiry or medical examination of an employee is "job-related and consistent with business necessity" when an employer "has a reasonable belief, based on objective evidence, that: (1) an employee's ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition." Periodic medical examinations and other monitoring under specific circumstances may be job-related and consistent with business necessity.

Employers may also require periodic examinations of employees in positions affecting public safety such as police officers and firefighters. Where examinations are required by safety regulations, an employee cannot assert an ADA claim as barrier to employer compliance with regulations.

Equally important are court cases that have held that physicians and other providers may not seek protection of disability discrimination laws where the provider poses a direct threat to the health and safety of other individuals in the workplace. 42 U.S.C.§ 12113(b); 42 U.S.C.§ 12182(b)(3). The term "direct threat" is defined in this section to mean "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation." 42 U.S.C.§ 12111(3).

The determination of whether an employee poses a direct threat must be based on "an individualized assessment of the individual's present ability to safely perform the essential functions of the job," which itself must be based on "a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence." 29 C.F.R. § 1630.2(r). This assessment should consider four factors: (1) the duration of the risk;

(2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. *Id.*

C. REASONABLE ACCOMMODATION

The final question here relates to the actions which are available should a screening examination reveal some form of process causing or potentially contributing to an impairment.

Under the ADA, an employer must make "reasonable accommodations" for disabled employees, unless such reasonable accommodations would cause an undue hardship to the employer. Disability is defined broadly under both federal and state disability discrimination laws. "In general, an accommodation is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities." 29 C.F.R. § 1630.2(o). This includes making modifications and adjustments for disabled individuals so they can be considered for positions, perform their job functions and equally enjoy the benefits and privileges of employment. 29 C.F.R. § 1630.2(o).

In the context of late-career practitioners, if a hospital medical staff is concerned about the ability of a practitioner to practice safely, it must undertake an interactive process with the person aimed at finding a way to reasonably accommodate him or her to enable him or her to practice safely. If after a concerted effort to reasonably accommodate the practitioner, the medical staff determines the practitioner still poses a public safety risk, it may then take action against the person without violating the ADA. As with all matters involving discrimination, these cases are viewed on an individualized basis.

It is imperative that due diligence be exercised to be sure that all necessary steps have been completed and documented before acting.

D. DEFENDING AGAINST A LEGAL CHALLENGE

In order to defend a policy against a legal challenge, it is important that the screening required by the policy accurately assesses a physician's capacity to perform the privileges requested. See Appendix A: Regarding the Evidence of Validity, Predictability, and Reliability.

In order to defend a policy on patient-safety grounds, the age at which the policy goes into effect should have a direct connection to the age at which there is an increased risk of age-related impairments. As such, institutions should monitor the research related to age-related impairments and regularly reassess their policies to ensure that the age the policy goes into effect accurately reflects the current literature on the subject.

As noted above, in order to avoid claims for violation of the ADA, the medical staff must engage in an interactive process with the practitioner and make reasonable accommodations to enable him or her to continue to practice safely, if possible, in light of the results in the reports of the further evaluations performed.

VIII. RESTATEMENT OF PURPOSE

All of the steps associated with age-related screening of a health care professional have the potential to contribute positively to the safety of patient care as well as to the best interests of the individual practitioner. This document has been prepared as a reference and guide to assist all parties in the process—the individual practitioner and those who prepare, adopt, implement, comply with, and defend policies and procedures for age-related screening. The contents of this document do not replace the judgment of the responsible parties applied to individual circumstances.

IX. GUIDELINES AND DOCUMENTS CITED

Evaluations of Health Care Professionals. California Public Protection & Physician Health (CPPPH 2013) Available from www.CPPPH.org

Making Informed Choices: Guidelines for Selecting Physician Health Services Professionals. California Public Protection & Physician Health (CPPPH 2012) Available from www.CPPPH.org

Guidelines for Physician Well-Being Committee Policies and Procedures (CMA ON-CALL Document #5177) Available from www.CPPPH.org

California Medical Association Model Medical Staff Bylaws (CMA 2013)

X. APPENDICES

A. APPENDIX A: REGARDING THE EVIDENCE OF VALIDITY, PREDICTABILITY, RELIABILITY OF SCREENING INSTRUMENTS

The purpose of the assessment of cognitive function is to evaluate the practitioner's capacity to perform the privileges requested, and this requires attention to the choice of the evaluator, the screening instrument(s) used, and the process the evaluator follows.

Screening instruments commonly used are the MicroCog™, St. Louis University Mental Status (SLUMS) Examination, or Montreal Cognitive Assessment. The MicroCog ™ is frequently chosen because it is quick to administer and is more well known than other instruments.

Ideally, the screening instrument would be one for which there are published studies conducted with a population comparable to the population of health care practitioners we are working with in this context, but such studies have not been done. For example, the published studies of the MicroCog ™ are ones conducted on a general population, not on a population comparable in education level, characteristics and abilities to physicians. Therefore, we rely on the evaluator to interpret the results of the testing in a way that takes these factors into consideration rather than using only the norms from the general population.

The evaluator must factor in the differences between the education-adjusted norm based on the general population and the background and characteristics of the person being tested when the person is a physician. This is one of the reasons for the recommendation that even the first screening assessment of health care professionals be conduced by evaluators who have experience with this population.

Reference:
Wild K, Howieson D, Webbe F, Seelye A, Kaye J. Status of computerized cognitive testing in aging: a systematic review. Alzheimer's & Dementia. 2008;4:428-437.

B. APPENDIX B: SAMPLE FORMS

The forms provided here are examples only and may be useful as samples; each institution should design its own forms.

1. FORM REQUESTING AND REPORTING A MEDICAL ASSESSMENT

History and Physical Examination for Late Career Practitioners

NOTE TO THE EXAMINING PRACTITIONER

The Medical Staff of XXX, as a part of its efforts to protect both patients and practitioners, requires a comprehensive history and physical examination of practitioners applying or reapplying for clinical privileges beyond a certain age. Important components of this assessment include a review of systems that addresses functional status, and comprehensive sensory examinations including tests of hearing, visual acuity with eye chart and exam, and a thorough neurological exam. The elements of the examination should be modified as appropriate to address the age, clinical condition, medical problems and the clinical privileges requested by the practitioner. ***Therefore, please be sure to review the practitioner's requested privileges before conducting your examination***.

In order to respect the confidentiality of the practitioner's medical information, please submit **only** the form attached to this document when sending the results of your examination to the relevant Medical Staff office. As noted on the form, the Medical Staff is interested only in, and should receive a detailed report on only those aspects of the practitioner's health, if any, that have the potential to adversely affect the practitioner's ability to safely perform the requested privileges or that document his/her ability to do so. You may supply additional information that you feel would be helpful to the Medical Staff in this assessment.

Practitioner's Name:

_____

Requested Clinical Privileges:
See attached Clinical Privileges Delineation Checklist

History and Physical Attestation Form

I attest that I have performed a comprehensive history and physical examination on this practitioner, and that I have reviewed the clinical privileges requested by this practitioner.

In the history and physical examination the practitioner has no apparent findings that would necessarily preclude him/her from performing the privileges requested.
Agree: _____ Disagree: _____ If disagree, please elaborate below

In tests and studies performed on this practitioner, he/she has no apparent findings that would necessarily preclude him/her from performing the privileges requested.
Agree: _____ Disagree: _____ If disagree, please elaborate below

Do you have any recommendations for further study or evaluation?
No: _____ Yes: _____ If yes, please elaborate below

Additional Comments:

Name, specialty, contact information, and signature of the examining physician:

Name: _____ Specialty: _____

Email and phone: _____

Signature: _____ Date: _____

Please Fax the completed form to: _____

2. FORM REQUESTING AND REPORTING A NEUROPSYCHOLOGICAL ASSESSMENT

Cognitive Screening for Late Career Practitioners

NOTE TO THE EXAMINING NEUROPSYCHOLOGIST:

The Medical Staff of XXXXXX, as a part of its efforts to protect both patients and practitioners, requires a cognitive screening evaluation of practitioners applying or reapplying for clinical privileges beyond a certain age.

In order to protect the confidentiality of the practitioner's medical information, please use **only** the form attached to this document to submit the outcome of the screening to the relevant Medical Staff office. As noted on the form, the Medical Staff is only interested in, and should only receive a detailed report on, those aspects of the screening, if any, that have the potential to adversely affect the practitioner's ability to safely perform the requested privileges. You may supply additional information that you feel would be helpful to the Medical Staff in this assessment, including recommendations for further evaluation.

Practitioner's Name: _____

Requested Clinical Privileges:
See attached Clinical Privileges Delineation Checklist

Cognitive Screening Attestation Form

I attest that I have administered the cognitive screen requested by the relevant Medical Staff Office to this practitioner and have interpreted the results. I have also reviewed the clinical privileges requested by this practitioner and have taken these into account in my interpretation.

The results of these cognitive screens indicate that the practitioner has no apparent findings that would necessarily preclude him/her from performing the privileges requested.

Agree: _____ Disagree: _____ If disagree, please elaborate below.

_____

_____

_____

Do you have any recommendations for further study or evaluation?
No: _____ Yes: _____ If yes, please elaborate below.

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

Name, specialty, contact information, and signature of the examining physician:

Name: _____ Specialty: _____

Email and phone: _____

Signature: _____ Date: _____

Please return the completed form to: _____

3. FORM REPORTING A PEER ASSESSMENT

Confidential Peer Assessment Evaluation Report Form

APPLICANT NAME:

The above listed healthcare provider has made application for clinical privileges or practice prerogatives at one or more Name of Medical Center facilities. *Please complete all parts of this form with the check box marked*. If more room is required, please use Comment Section or a separate sheet.

A. PEER REFERENCE

☐ ***Please complete this portion of the form:***

How long have you known the applicant?	**From:**	**To:**

B. CLINICAL EVALUATION (*If your evaluation finds an area less than satisfactory in any category, please explain in the comment section or on a separate sheet*)

The evaluation should be based on demonstrated performance compared to that reasonably expected of a healthcare provider at his/her level of training, experience and background.	***Clinical Evaluation***		
	SATISFACTORY	***UNSATISFACTORY***	***UNKNOWN***
Patient Care: The practitioner provides patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at end-of-life			
Medical / Clinical Knowledge: The practitioner demonstrates knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.			
Practice Based Learning Environment: The practitioner uses scientific evidence and methods to investigate, evaluate, and improve patient care practices.			
Interpersonal and Communication Skills: The practitioner demonstrates interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.			
Professionalism: The practitioner demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.			
Systems Based Practice: The practitioner demonstrates both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.			
Technical & Clinical Skills & Judgment: The practitioner demonstrates the technical and clinical skills and judgment necessary to safely and competently render care, treatment, and service within the scope of privileges requested.			
History & Physical Exam Taking			
Record Keeping			
Case Presentations			
Patient Management			
Practitioner-Patient Relationship			

	SATISFACTORY	*UNSATISFACTORY*	*UNKNOWN*
Appearance			
Understand/Speak English			
Ability to Express Him/Herself in Written English			
Participation in Medical Staff functions/committees			

C. *PLEASE EXPLAIN ANY YES ANSWERS IN COMMENT SECTION OR ON A SEPARTE SHEET.

	Confidential Evaluation	YES	NO
1	Are you aware of any information that would indicate that the applicant is <u>not</u> able to perform all procedures for which he or she has requested clinical privileges or practice prerogatives, with or without reasonable accommodations required by the Americans with Disabilities Act, within accepted standards of professional performance and without posing a direct threat to patients? (NOTE: The Americans with Disabilities Act requires certain reasonable adjustment or modifications to assist disabled individuals in performing their jobs. These are termed "reasonable accommodations.")		
2	Are you aware of any information that indicates that the applicant currently, or in the last year, engages or engaged in the unlawful use of drugs, including the improper use of prescription drugs not under the supervision of a licensed health professional? If **<u>YES</u>**, please identify the drug(s) and the time period in which the applicant engaged in such use, including the last date used, if you have such knowledge If "YES", has that use interfered with the applicant's professional practice?__ YES ___ NO		
3	During the time noted under *Dates of Affiliation* on Page 1, are you aware of this healthcare provider ever being subject to any DISCIPLINARY ACTION, such as admonition, reprimand, suspension, termination or voluntary relinquishment of clinical privileges or practice prerogatives?		
4	To your knowledge, has this applicant ever been investigated or sanctioned because of utilization practices by a peer review organization, government or third party program?		
5	Are you aware of any facts regarding him/her which cause you to hesitate in any way in recommending him/her for clinical privileges or practice prerogatives at a Memorial Medical Center facility?		

D. *PLEASE COMPLETE BY CHECKING THE APPROPRITE BOXES

	RECOMMENDATIONS	√
A	**Recommended as qualified and competent**	
B	**Recommended with some reservation**	
C	**Do not recommend**	
D	**No comment**	

	REPORT IS BASED ON:	√
A	**Close personal observation**	
B	**General impression**	
C	**A composite of evaluations by supervisors**	
D	**Other (Please explain in Comment Section or a separate sheet)**	

***<u>COMMENTS</u>: (Please note strengths/weaknesses, comments regarding clinical privileges or practice prerogatives requested, etc., and explain any answers to above questions)**

Date _____ **Signature:** _____

Printed Name & Title: _____

4. FORM REPORTING OBSERVATIONS FROM NURSING STAFF OR OTHERS IN THE CLINICAL SETTING

Floor Nursing Manager: Evaluation Of Practitioner Under Evaluation

Confidential Evaluation Form

This evaluation tool is an integral component of the reappointment process for late-career medical staff members of Name of Medical Center and/or Name of Hospital. In an attempt to review the practitioner's overall performance in all phases of patient care, we would appreciate your participation in completing this evaluation. Professional, confidential discussion of these specific areas with your nursing staff may be of benefit in the accurate completion of this evaluation.

Thank you for your participation and time in assisting us with the reappointment process.

DATE: _____

Practitioner: _____ Specialty: _____

Primary Evaluator: _____ Phone: _____

Please evaluate this practitioner in the following areas by placing an "X" in the appropriate boxes below.

	ACCEPTABLE	UNACCEPTABLE
Overall, verbal and written communication with staff has been clear and timely	☐	☐
Practitioner consistently responds appropriately to nursing concerns regarding patient status	☐	☐
Progress notes consistently reflect a clear plan of care and practitioner is involved in discharge planning efforts	☐	☐.
Practitioner consistently responds to pages in a timely manner	☐	☐
Patient and significant others seem cognizant of health care issues and practitioner's proposed treatment plan	☐	☐

COMMENTS:

_____ _____ _____

Signature, Nursing Manager Please Print Name Date

QUALITY ASSESSMENT RECORDS ARE NON-DISCOVERABLE UNDER CALIFORNIA EVIDENCE CODE 1157 AND ALL EVALUATION FORMS SHOULD BE KEPT IN MEDICAL STAFF SERVICES UPON COMPLETION. ONCE COMPLETED, PLEASE DO NOT KEEP A COPY. THANK YOU.

3/11 EVAL FORM NURSING FLOOR MGR

C. APPENDIX C: MODEL MEDICAL STAFF BYLAWS

This appendix presents exemplar language, shown in italics, for relevant portions of a medical staff bylaws to support and implement the policies discussed in this document. The California Medical Association's Model Medical Staff Bylaws have been used as a sample solely for illustrative purposes. Please note that CMA has not adopted any of the exemplar language into its model bylaws, and other model or actual medical staff bylaws may vary slightly.

DEFINITIONS
INVESTIGATION
The language should note that activities of the Wellbeing Committee do not constitute investigation.

NONDISCRIMINATION
No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, or sexual orientation *that does not pose a direct threat to patient safety or the quality of patient care*.

QUALIFICATIONS FOR MEMBERSHIP
Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on professional training, experience and current competence criteria as set forth in these bylaws.
General Qualifications
Only physicians, [dentists] [podiatrists] [clinical psychologists] shall be deemed to possess basic qualifications for membership in the medical staff . . . . and who,

(a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and *(5) current adequate physical and mental health status, including satisfying age-based screening and assessment as may be applicable*, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive safe, quality medical care;

APPLICATION FOR MEMBERSHIP AND MEMBERSHIP
General
Except as otherwise specified herein, no person shall exercise clinical privileges in the hospital unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws. By applying to the medical staff for initial membership or renewal of membership, the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies *and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time*. Membership on

the medical staff shall confer on the member only such clinical privileges as have been granted in accordance with these bylaws.

Effect of Application
By applying for membership or renewal of membership on the medical staff, each applicant:

(a) Signifies willingness to appear for interviews in regard to the application;
(b) As may be applicable, agrees to satisfy age-based screening and any reasonable follow-up assessment requested by the Wellbeing Committee;

CREDENTIALS COMMITTEE
Composition
The credentials committee shall consist of not less than [ ] members of the active staff selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the staff departments.

Duties
The credentials committee shall:

(a) review and evaluate the qualifications of each practitioner applying for initial membership, renewal of membership, or modification of clinical privileges, and, in connection therewith, *obtain and consider the recommendations of the Wellbeing Committee* and other appropriate departments; * * * *

WELLBEING COMMITTEE
Composition
The Wellbeing Committee shall be comprised of no less than [ ] active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of [ ] years, and the terms shall be staggered as deemed appropriate by the executive committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

Duties
The Wellbeing Committee may receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action.

The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities.

The committee shall also develop and implement a uniform policy for age-based screening and assessment of applicants for and members of the medical staff. The purposes of the policy shall be to protect patient safety, to safeguard the rights and privileges of practitioners and to provide support for aging practitioners. The Wellbeing Committee may consult with legal counsel for the medical staff for assistance. Any policy and amendments or modifications thereto shall be approved by the medical staff [OR MEDICAL EXECUTIVE COMMITTEE] in accordance with procedures established in these bylaws.
At a minimum, the policy must:

1) *Provide that the Wellbeing Committee is charged with conducting age-based screening and any follow up assessments as reasonably necessary but shall have no authority to take disciplinary action or any action related to privileging, but will report its findings to the Credentials Committee;*
2) *Specify that the requirement for age-based screening and assessment be based solely on the age of a practitioner and applies equally and uniformly to all applicants for and members of the medical staff who have reached the specified age;*
3) *Specify the age at which age-based screening and assessment shall begin to apply. The age requirement shall have a direct connection to the age at which there is an increased risk of age-related impairments, as documented in the scientific and medical literature. The Wellbeing Committee shall regularly monitor the research related to age-related impairments and modify the policy for age-based screening an assessment as appropriate;*
4) *Establish the frequency with which reassessments are required for reappointment of practitioners above the specified age;*
5) *Determine who pays for the costs of the age-based screening and assessment in a manner that minimizes undue burden on the individual practitioner while also ensuring efficacy and stability of the age-based screening and assessment program;*
6) *Establish protections and confidentiality of all documents and information about a practitioner undergoing age-based screening and assessment, with appropriate exceptions for the protection of patients. The Wellbeing Committee shall develop a standard release form to permit evaluators' reports to be shared with the Wellbeing Committee;*
7) *Establish criteria for identifying and using qualified evaluators; and*
8) *Specify the consequences that may be taken if a practitioner unjustifiably fails to cooperate with the age-based screening and assessment program.*

D. APPENDIX D: WELLBEING COMMITTEES

Guidelines for Physician Well-Being Committees Policies and Procedures (CMA On-Call Document #5177 September 2013) describe the role and function of wellbeing committees for medical staffs according to The Joint Commission Standards. The Committee provides a source of expertise whereby the medical staff may identify health factors underlying a clinical performance problem for which corrective action is under consideration. In the context of a formal investigation regarding clinical performance being conducted by the Medical Executive Committee or similar entity within the organization, the Well-Being Committee may be called upon to determine the presence, and the nature, of an underlying problem and make recommendations related to such problems.

An "individual health" or well-being function is mandated by the Joint Commission and is implemented by a committee of the medical staff. According to Standard MS.11.01.01, a medical staff must implement "a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes."

E. APPENDIX E: FREQUENTLY ASKED QUESTIONS

1. DO HIPAA PROTECTIONS APPLY TO THE REPORTS OF THE SCREENING OR THE FULL EVALUATIONS?

The Privacy Rule set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects all "individually identifiable health information," which can become "protected health information" (PHI). The question of HIPAA's application to health information received in a screening evaluation or other examination may change depending upon the legal relationship between the physician and the entity requesting the evaluation. For employed physicians evaluated by their employer, HIPAA defines PHI to EXCLUDE any health information in employment records held by a covered entity in its role as employer. [45 CFR Section 160.103] "Employment records" isn't defined, but the Department of Health and Human Services has clarified that medical information needed for an employer to carry out its obligations under the Americans with Disabilities Act and similar laws, as well as files or records related to fitness for duty tests, are part of employment records and not subject to HIPAA. Secondly, California law has special provisions that apply to employers' use and disclosure of employee health information [Civil Code Section 56.20].

In the context of a hospital medical staff that performs screening of physicians as part of its privileging process, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. Health care operations include competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation.

It should be noted that HIPAA and state confidentiality laws contain numerous limitations and exceptions to the use and disclosure of PHI and this document is not in any way intended to neither provide legal advice nor speak to the application of HIPAA and state confidentiality laws in specific instances.

The best way to avoid any potential confidentiality issues is to require physicians to sign a waiver of their privacy rights under HIPAA or state law. It should be noted, however, that the rules regarding an appropriate consent under HIPAA and state law also contain certain conditions and limitations. Counsel should be consulted for assistance and guidance in creating consent documents.

2. WHAT IS THE RELATIONSHIP BETWEEN AGE-BASED SCREENING AND A FITNESS FOR DUTY EVALUATION?

The results of a screening assessment are used to learn whether there are areas of health or abilities that require further evaluation in order to determine whether they affect performance. "Age-based screening" in a medical staff, for example, is conducted for all persons when they reach a certain age regardless of any other factors such as health or performance. If the

information from a screening assessment raises a question about the evaluee's health and abilities, further evaluation is needed before conclusions or recommendations can be developed.

The term "fitness for duty evaluation" describes an evaluation or set of evaluations comprehensive enough to allow the evaluator to make observations and recommendations about whether the evaluee's health and abilities are sufficient to allow him/her to perform the duties of his/her role and function safely.

A fitness for duty evaluation is different from a clinical evaluation in that the focus is not on diagnosis or illness, but on ability to perform current duties. If the purpose of an evaluation is to determine fitness for duty, the report must include focused observations and conclusions of the evaluator about whether, and if so how, the evaluee's health and abilities support or do not support the safe practice of his/her role and duties.

3. What must be reported to the Medical Board of California and the National Practitioners Data Bank?

California and federal law require reports to be filed with the Medical Board of California (MBC) and/or the National Practitioner Data Bank (NPDB) whenever action taken by a peer review body results in denial of an application, suspension, restriction or loss of medical staff privileges or employment. Under Business and Professions Code Section 805, the denial of an application for appointment or reappointment, or the suspension, restriction or loss of medical staff privileges or employment, must be for a "medical disciplinary cause or reason." Any restriction imposed or voluntarily accepted must remain in effect for a cumulative total of 30 days or more within a 12-month period. A summary suspension must be reported after it has been in effect for 14 consecutive days. Summary suspension requires that the peer review body determine that the failure to take action immediately may result in imminent danger to the health of any individual.

A report must also be filed pursuant to 805 when a physician resigns, takes a leave of absence, or withdraws or abandons an application for appointment or renewal while under investigation for a medical disciplinary cause or reason. Business and Professions Code section 805 defines medical disciplinary cause or reason as "that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care."

The Healthcare Quality Improvement Act (HCQIA) of 1986 42 U.S.C. Section 11133 requires healthcare entities to report any professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days. A "professional review action" is defined in 42 USCA Section 11151(9) as an action or recommendation of a professional review body "which is based on the competence or professional conduct (which conduct affects or could affect adversely the health and welfare of a patient or patients)".

HCQIA further requires that healthcare entities report the surrender of a practitioner's clinical privileges while under investigation relating to possible incompetence or improper conduct or in return for not conducting such an investigation or proceeding.

The Medical Board of California must submit the information received from the healthcare entity to the NPDB within 15 days of the date it was received (45 C.F.R. Section 60.5(c)).

In the context of age-based screening of late-career practitioners, the questions related to reporting depend entirely upon the specifics of the situation, and state laws will differ in their reporting requirements. We do not believe that a routine age based screening examination as part of an application for appointment or reappointment constitutes an "investigation for medical disciplinary cause or reason" as defined in Section 805 or an investigation relating to incompetence or improper conduct under HCQIA. If a routine physical, cognitive or peer review-based evaluation reveals information that creates concerns regarding the practitioner, the question of whether the action taken by the peer review body is a reportable action under state or federal law will depend upon multiple variables and the steps taken to address the concerns. Not everything a medical staff or physician group might do in response to concerns raised during a screening examination will constitute a reportable event and this task force urges that the focus be upon physician wellbeing as opposed to discipline. For example, actions taken by the practitioner on the recommendation of the Wellbeing Committee in which the practitioner takes the initiative to limit his/her own privileges or status should not be considered disciplinary actions. If, however, actions of the peer review body or professional review body are required in order to place limits on the privileges or status of the practitioner because of quality of care concerns, reporting statutes must be followed.

Physicians and hospitals should consult their bylaws and seek guidance from counsel if questions arise in responding to any concerns generated by a positive finding in an evaluation.

F. APPENDIX F: REFERENCES

Boom-Saad Z, Langenecker SA, Bieliauskas LA, Graver CJ, O'Neill JR, Caveney AF, Greenfield LJ, Minter MD. Surgeons outperform normative controls on neuropsychologic tests, but age-related decay of skills persists. The American Journal of Surgery. 2008;195:205-209.

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G. APPENDIX G: LEGAL ASPECTS OF AGE-BASED SCREENING

Given the demographic trends, clinical evidence and public discussion, there are legitimate concerns among institutions that the failure to employ mechanisms to better identify providers manifesting early physiologic and cognitive changes may put patients at risk and subject hospitals and physician groups to liability for failing to address the issue. Most prevalent has been the question of whether age-based screening policies should be added to the extensive network of peer review, quality assurance/performance improvement, impaired physician policies, and physician wellbeing programs already in place to assist physicians and fulfill the obligations of institutions to ensure quality. One of the primary barriers to implementation of age-based screening requirements is the concern that such measures conflict with well-established age and disability discrimination laws at both the federal and state levels. For better or worse, healthcare institutions were not among the multiple professions for which exceptions were created by Congress, the courts and industries for mandatory hiring and retirement ages and medical examinations based on age.

The AMA estimates that only 5-10% of hospitals have implemented policies which vary between combinations of physical examinations, cognitive examinations and focused peer review for clinicians that reach a particular age. Some require testing at age 70 and others 75. Others include shorter reappointment periods for practitioners beginning at 70 or 75. We are unaware of any hospitals contemplating an age limit for granting privileges to physicians practicing on their medical staffs. In contrast to hospitals, mandatory retirement policies for physician groups are not at all uncommon. Mandatory retirement ages of 65 and 70 are present in many physician group agreements accompanied by mechanisms that allow a practitioner to continue practicing under certain circumstances. Most notable is that California has included an exception in its age discrimination statute that allows physician groups to retire physicians at age 70.[7]

1. THE EVOLUTION OF AGE DISCRIMINATION LAWS

a) LEGISLATION

Federal and state age discrimination laws have followed a very different path than laws prohibiting workplace discrimination based on race, religion, national origin, gender and sexual orientation. Notwithstanding decades of discussion of the impact of mandatory retirement of employees at age 65 by employers, age discrimination was not included in the landmark 1964 Civil Rights Act which outlawed discrimination in the workplace. Congress demanded that the issue of age discrimination be studied further because it was viewed as different from other forms of invidious discrimination. The difference resided in the recognition that conditions associated with age can impact job performance in ways that endanger the employee, others in the workplace or the general public. In 1967, Congress ultimately passed the Age Discrimination in Employment Act ("ADEA").

In the ADEA, Congress declared it "unlawful for an employer to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions or privileges of employment, because of such individual's age". Despite this

[7] *See* California Government Code Section 12942(c).

sweeping statement, Congress saw no contradiction in establishing laws in the years surrounding passage of the ADEA which mandated retirement for certain professions, including: pilots at age sixty[8] (1959); air traffic controllers at age fifty-six (1972); and federal law enforcement and firefighters at age fifty-five (1974). Additional mandatory retirement ages were established in subsequent years for nuclear materials couriers, customs and border protection officers, the Central Intelligence Agency, and the Federal Bureau of Investigation.[9]All of these policies rested on concern for the public.

The difference in the way age was viewed is also reflected in the evolution of the scope of the ADEA's protections. Originally, the law applied only to employees between the ages of forty and sixty-five. It was amended in 1978 to extend the upper age to seventy, and then again in 1986 at which time Congress removed the upper age limit completely. Because the 1986 amendments extended protection to *all* workers over forty, Congress was lobbied to include exceptions. In particular, the 1986 amendments allowed institutions of higher education to impose compulsory retirement for tenured faculty and educators at age seventy (this was eventually eliminated in 1993)[10]; and allowed companies to retire "highly paid executives" at age 65 under certain prescribed conditions. Most significantly, Congress took no action to eliminate the mandatory retirement and screening requirements for pilots, air traffic controllers, law enforcement and others.

States have also evolved in their treatment of age discrimination legislation. It was not until the past decade that all states had passed statutes prohibiting discriminatory practices based on age. Like Congress, states have their own exceptions in their statutes as reflected in California Government Code Section 12942(c).

b) THE TREATMENT OF AGE DISCRIMINATION IN THE COURTS

Initially, courts applied a very deferential standard in reviewing age-based hiring and retirement policies in the airline, bus and law enforcement contexts. The policies were defended on the grounds that individualized testing and monitoring of job performance was *inadequate* to protect against catastrophic health related events, particularly in the context of mass transportation. The assumption was that age increased the probability of such events and that no amount of testing could rule out a sudden stroke, cardiac event or other incapacitating condition. In these early cases, the courts asked only whether the legislature or industry had a rational basis for believing that hiring and retirement at a particular age were appropriate proxies for a system of individualized testing. They further focused on admissions by experts testifying for those challenging the policies that testing could not *completely* eliminate the risk of a catastrophic event.

Over time, courts have become more demanding of legislatures and industries to demonstrate that age-based measures are necessary and superior to individualized testing and monitoring. One of the mechanisms adopted by the courts scrutinizing these policies is to closely examine the job functions involved. Thus, while courts have accepted the mandatory retirement age requirements for commercial pilots, a policy mandating retirement for flight *engineers* was rejected by a court. The court felt that the airline and FAA could not demonstrate the same degree of risk to passengers

[8] *See* 49 U.S.C. § 44729.
[9] *See* 5 U.S.C. § 8335.
[10] See 29 C.F.R. § 1625.11.

posed by a sudden medical event with an engineer as compared with an event involving a captain. Similarly, a court rejected an age-based retirement policy applied to a fire *chief* whose job functions were not viewed by the court as the same as front line firefighting personnel.

As alluded to above, there are important cautionary notes to be advanced in looking at the judicial treatment of age discrimination claims. Primary among them is that almost all of the cases adjudicating age-based restrictions involve mandatory *hiring or retirement* policies, not age-based screening. While there are clearly concerns with abuses that might arise from medical screening, one gets the sense that mandatory hiring and retirement policies are perceived by courts to create greater harm because the result is to definitively deprive the worker of the ability to pursue his or her chosen field. Courts in many cases have based their holdings against arbitrary age limitations for hiring and retirement on the ground that individualized testing was available, reliable and more consistent with the underlying values of protecting workers from discriminatory practices.

2. ELEMENTS OF A PHYSICIAN CLAIM OF AGE DISCRIMINATION

While there is a scarcity of cases dealing with the implementation of age-based *policies* in healthcare, there are numerous cases involving claims of age and other forms of discrimination by physicians against academic institutions, hospitals and physician groups. These cases involve allegations by individual physicians that age, disability or some other type of discrimination was the motivation for an institution's termination or restriction of their employment or medical staff privileges. These cases provide guidance on the application of the required elements of discrimination claims to physicians and thus provide insight into the legal doctrines that would govern a claim against an age-based policy. This is particularly meaningful in the context of medical staff actions given the basic requirement that age and disability discrimination laws apply only in the *employment* relationship.

a) THE EMPLOYEE VS. INDEPENDENT CONTRACTOR ELEMENT

The ADEA and Title VII of the 1964 Civil Rights Act apply only to employers and employees, not independent contractors. Where a claim for age or other form of discrimination under Title VII is brought by an employed physician, this element is satisfied. In the context of a physician claiming discrimination by a hospital medical staff against his or her privileges, however, courts have more often than not concluded that the physician is an independent contractor, thereby precluding the claim.[11] These cases have recognized that medical staff membership is inherently one in which the hospital is not exercising control over the physicians diagnosis and treatment of patients and thus does not fit the definition of an employment relationship.

[11] *Kuck v. Bensen*, 647 F.Supp. 743 (D. Me. 1986) (emergency room physician not an employee in ADEA challenge to the reduction of emergency room privileges); *Vakharia v. Swedish Covenant Hosp.* 190 F.3d 799 (7th Cir. 1999) (anesthesiologist not an employee under Title VII and the ADEA in challenge to termination of her hospital medical staff privileges); *Bender v. Suburban Hosp., Inc.,* 159 F.3d 186 (4th Cir. 1998) (physician not an employee under Title VII in gender discrimination claim against hospital that denied her medical staff privileges); *Alexander v. Rush North Shore Medical Center,* 101 F.3d 487 (7th Cir. 1996) (physician not an employee in Title VII action against hospital for alleged discriminatory termination of staff privileges); and *Shah v. Deaconess Hosp.*, 355 F.3d 496 (6th Cir. 2004) (surgeon not an employee in ADEA and Title VII action challenging termination of his surgical privileges).

There are other cases, however which render this question less clear. The *Salamon v. Our Lady of Victory* case is a prime example. In *Salamon*, the Court used a manner-and-means test to determine whether the physician was an "employee" of the hospital. The Court focused on whether the hospital had the right to control the "manner and means" by which the physician accomplished her work at the hospital. The Court determined that analysis of any employment relationship is fact-specific, and that each case requires scrutiny of the specific relationship between the parties. Staff privileges alone did not decide Salamon's employment status. The court held that it could not determine as a matter of law that the physician plaintiff was an independent contractor and allowed that question to be submitted to the jury.

Courts have also created a test which focuses on the *effect* of the hospital's action as opposed to the relationship between the physician and the medical staff. Specifically, courts have allowed physician's to proceed with discrimination claims if the hospital's actions interfered with the physician's employment opportunities with third parties. By focusing on the question of interference, courts have opened an avenue for physicians challenging medical staff actions that might otherwise have been foreclosed by the employer-independent contractor analysis.

b) THE BONA FIDE OCCUPATIONAL QUALIFIED QUALIFICATION ("BFOQ") DEFENSE

Title VII and the ADEA permit employers to engage in what might otherwise be considered discriminatory hiring and discharge policies where the policy or practice is based on a "bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise." It is this exception that allows for religious institutions to hire employees of their religious affiliation; for prisons to hire only male guards in "contact" areas of a maximum security prison; for weight and physical fitness requirements for paramedics; and for positions which require contact with individuals that require privacy. The BFOQ defense does not apply in the case of race or disability discrimination.

Laws, regulations and industry policies have survived judicial scrutiny in many cases because the courts have agreed that age can serve as a bona fide qualification under certain circumstances. In cases examining the BFOQ defense in claims of age discrimination, courts conduct a case-by-case analysis examining the specific job at issue; the risks to the employee or public associated with the job; the specific age or age range in the policy; the consequence of the policy (e.g., retirement); and the evidence as to the necessity of using the specific age in the policy in the circumstance before the court. Most relevant is the common theme that the presence of legitimate safety concerns, particularly to the public, lessens the burden required to defend an age-based policy.

As set forth above, the health care industry has simply not been the focus of either legislation or court cases examining age-based policies, thereby leaving a great deal of uncertainty as to how a policy might fare in a BFOQ analysis. It is clear however, that patient safety is the overwhelming driver of the examination of the utility and need for age-based screening of providers and would play a major role in any arguments before the courts.

3. DISABILITY DISCRIMINATION LAWS

The question of age-based testing also implicates laws which prohibit discrimination based on an individual's disability. The federal American's with Disabilities Act ("ADA") and Rehabilitation Act of 1973, as well as state laws prohibiting disability discrimination, impose restrictions on an employer's ability to inquire regarding medical conditions and to deny an individual the right to work based on a disability. Unlike age discrimination laws which might preclude a physician's claim against a medical staff because the physician is not an employee, the courts have held that Title III of the ADA does apply in the medical staff context.

a) SCREENING EXAMS

Generally speaking, an employer or medical staff can, and must, take a physician's health into account in both the hiring and privileging process.[12] Disability discrimination laws do not expressly preclude disability related inquiries nor medical screening examinations. Rather it places certain limits on the stage at which health related inquiries can be made, and the scope of any inquiry. According to the EEOC, "[t]he ADA's provisions concerning disability-related inquiries and medical examinations reflect Congress's intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can efficiently perform the essential functions of the job."[13]

An employer may make disability related inquiries and require a medical examination only if they are "job related and consistent with business necessity." A disability-related inquiry or medical examination of an employee is "job-related and consistent with business necessity" when an employer "has a reasonable belief, based on objective evidence, that: (1) an employee's ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition. Periodic medical examinations and other monitoring under specific circumstances may be job-related and consistent with business necessity.[14]

Employers may also require periodic examinations of employees in positions affecting public safety such as police officers and firefighters.[15] Where examinations are required by safety regulations, an employee cannot assert an ADA claim as barrier to employer compliance with regulations. Equally important are court cases which have held that physicians and other providers may not seek protection of disability discrimination laws where the provider poses a direct threat to the health and safety of other individuals in the workplace. [16] The term "direct threat" is defined in this section to mean "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."[17]

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[12] *See* Joint Commission Comprehensive Accreditation Manual for Hospitals, MS.06.01.05(6).
[13] EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000). http://www.eeoc.gov/policy/docs/guidance-inquiries.html
[14] EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000). http://www.eeoc.gov/policy/docs/guidance-inquiries.html
[15] EEOC Guidance on Disability Related Inquiries and Medical Examinations (2000). http://www.eeoc.gov/policy/docs/guidance-inquiries.html
[16] 42 U.S.C.§ 12113(b); 42 U.S.C.§ 12182(b)(3).
[17] 42 U.S.C.§ 12111(3). *See also Sch. Bd. of Nassau Cnty., Fla. v. Arline*, 480 U.S. 273 (1987).
It is worth noting that the definition of direct threat in the EEOC's regulations adds additional language to the ADA's definition. The regulation states that a direct threat is "a significant risk of **substantial harm** to the health or safety

The determination of whether an employee poses a direct threat must be based on "an individualized assessment of the individual's present ability to safely perform the essential functions of the job," which itself must be based on "a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence."[18] This assessment should consider four factors: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm.[19]

b) REASONABLE ACCOMMODATION

The final question here relates to the actions which are available should a screening exam reveal some form of process causing or potentially contributing to an impairment. Under the ADA, an employer must make "reasonable accommodations" for disabled employees, unless such reasonable accommodations would cause an undue hardship to the employer. Disability is defined broadly under both federal and state disability discrimination laws. "In general, an accommodation is any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities."[20] This includes making modifications and adjustments for disabled individuals so they can be considered for positions, perform their job functions and equally enjoy the benefits and privileges of employment. [21]

In the context of late-career practitioners, if a hospital is concerned about the ability of a physician to safely practice medicine, it must undergo an interactive process with the physician aimed at finding a way to reasonably accommodate him or her to enable him or her to practice safely. If after a concerted effort to reasonably accommodate the physician, the hospital or physician group determines the physician still poses a public safety risk, it may then take action against the physician without violating the ADA. As with all matters involving discrimination, these cases are viewed on an individualized basis and it is imperative that caution be exercised to be sure that all necessary steps have been completed and documented before acting.

4. DEFENDING AGAINST A LEGAL CHALLENGE

In order to defend a policy against a legal challenge, it is important that the screening required by the policy accurately assesses a physician's capacity to perform the privileges requested. See Appendix A: Review of the Evidence of Validity, Predictability, Reliability.

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of the individual or others that cannot be eliminated **or reduced** by reasonable accommodation." 29 C.F.R. § 1630.2(r). (Language added to the regulation is in bold).

[18] 29 C.F.R. § 1630.2(r).

[19] 29 C.F.R. § 1630.2(r).

[20] 29 C.F.R. § 1630.2(o).

[21] 29 C.F.R. § 1630.2(o). The ADA regulations set forth three categories of reasonable accommodations: "(i) modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires; or (ii) modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position; or (iii) modifications or adjustments that enable a covered entity's employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities." 29 C.F.R. § 1630.2(o)(1)(i-iii).

In order to defend a policy on patient-safety grounds, the age at which the policy goes into effect should have a direct connection to the age at which there is an increased risk of age-related impairments. As such, institutions should closely monitor the research related to age-related impairments and regularly reassess their policies to ensure that the age the policy goes into effect accurately reflects the current literature on the subject.

In order to avoid claims for violation of the ADA, the medical staff must engage in an interactive process with the practitioner and make reasonable accommodations to enable him or her to continue to practice safely in light of the results in the reports of the further evaluations performed.

Appendix G was prepared by Richard Barton, Jamie Quient and Natalie Mueller of the firm Procopio, Cory, Hargreaves & Savitch LLP in San Diego.

Although the information contained herein is provided by professionals at Procopio, the content and information should not be used as a substitute for professional services. If legal or other professional advice is required, the services of a professional should be sought.

California Public Protection & Physician Health, Inc.
575 Market Street, Suite 2125, San Francisco, CA 94105
(415) 764-4822 cppphinc@gmail.com www.CPPPH.org